

Child Registration

Patient's Name _____ Date of Birth _____
Mailing Address _____ []Male []Female
City _____ State _____ Zip Code _____
Social Security Number _____ **How did you hear about us?** _____

Responsible Party (if other than patient)

Responsible Party _____ Relationship _____
Email Address for Appointment Confirmations _____

Mother's Information: Name _____ Date of Birth _____

Mailing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____
May we send you a text? [] Y [] N

Social Security Number _____ Employer _____ Occupation _____
(REQUIRED)

Father's Information: Name _____ Date of Birth _____

Mailing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____
May we send you a text? [] Y [] N

Social Security Number _____ Employer _____ Occupation _____
(REQUIRED)

Insurance Information: Insurance Company Name _____ Phone _____

Policy Holder _____ Group ID _____

Relationship _____ Social Security Number _____ Date of Birth _____

Appointment Policy

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each appointment. Missed appointments add to the cost of dental care when these reserved facilities are left waiting. We require **48 HOUR** advance notice for rescheduling appointments. We reserve the right to charge a fee for a broken or cancelled appointment without **48 HOUR** notice.

Insurance and Financial Policy

Total payment is appreciated at the time of service. We accept Cash, Check, Visa, MasterCard, or Discover. We also offer 12 month interest free financing through Care Credit. We are in network with many PPO plans; however your insurance policy is a contract between you, your employer and the insurance company. We are not part of that contract except to accept the insurance company's fees. In the event we do not receive payment from your insurance company within 90 days of filing a claim with them, the balance will be your responsibility. You are ultimately responsible for any services not paid by your insurance company. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Your treatment plan is individually tailored to your dental needs and is not based on your dental insurance benefits and what they may or may not deem as necessary. This office does not use amalgam (silver) fillings. We place only white resin (tooth colored) fillings. This may or may not be covered by your policy. In order to give you an estimate of cost for your needed dental treatment, we will verify your insurance benefits prior to treatment but they will only give us a basic breakdown of benefits. It is your responsibility to know your contract limitations. It is your responsibility to fully understand the coverage and exceptions of your particular policy. The parent that accompanies the minor child and signs for them is responsible for any payment due on the account.

Consent for Dental Treatment

I hereby give Dr. Tristan H. Greenwalt, Dr. Angela L. Greenwalt, and any of the associates of Lady's Island Dental, PC my consent for dental treatment. I have read and fully understand the above stated policies and I agree to abide by them. I grant permission to you or your assignee, to telephone me at any phone number above to discuss matters related to this form and to my dental treatment. By signing this form, I further authorize the release of information to my insurance provider.

Parent or Guardian Signature

Date
